TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ASHKAN BIDGOLI, DO

Respondent Name
WC SOLUTIONS

MFDR Tracking Number
M4-16-0654-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we believe the enclosed documentation supports the assignment of CPT code 99285 in this case."

Amount in Dispute: $1,100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Emergency Room record provides adequate history and examination. However, the documentation does not support the presenting problem was of high severity and posed an immediate significant threat to life. There are no test results or other findings to support the presenting problem was a high severity and posed a significant threat to physiologic function. Due to the nature of the presenting problem and there was not a significant threat to physiologic function, our position remains that the level of service was not met."

Response Submitted By: Starr Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2014	CPT Code 99285 Emergency Department Visit	$1,100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.

4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 150-Documentation submitted does not support the requirements for billing for code 99285 emergency department visit are met.
   - W3-Additional reimbursement made on reconsideration.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - W3, 193-Per rule 134.904, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Original payment decision is being maintained.

Issues

Does the documentation support billing code 99285? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 99285 is defined as "Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function."

   A review of the submitted medical report does not support the documentation requirement for code 99285, specifically medical decision making of high complexity; therefore, the respondent's denial is supported. As a result, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/09/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.